		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0021550

Facility Name: BOURBONNAIS TERRACE

Address: 133 MOHAWK DR. (Number) BOURBONNAIS (City) 60914 (Zip Code)

County: KANKAKEE

Telephone Number: (847) 674-5795 **Fax #** (847) 674-5794

IDPA ID Number: 36-2821184

Date of Initial License for Current Owners: 01/01/78

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[X]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) GENERAL PARTNER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	100	Skilled (SNF)	100	36,500	1
2		Skilled Pediatric (SNF/PED)			2
3	97	Intermediate (ICF)	97	35,405	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	197	TOTALS	197	71,905	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	67,072	1,136		68,208	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	67,072	1,136		68,208	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.86%

D. How many bed-hold days during this year were paid by Public Aid?
1,740 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/76

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	258,258	18,065	9,630	285,953		285,953		285,953			1
2	Food Purchase		239,621		239,621		239,621	(1,176)	238,445			2
3	Housekeeping	204,630	21,429		226,059		226,059		226,059			3
4	Laundry	91,563	15,567	3,902	111,032		111,032		111,032			4
5	Heat and Other Utilities			127,278	127,278		127,278	441	127,719			5
6	Maintenance	24,020	8,073	39,300	71,393		71,393	5,367	76,760			6
7	Other (specify):* Scavenger/Security			8,745	8,745		8,745	132	8,877			7
8	TOTAL General Services	578,471	302,755	188,855	1,070,081		1,070,081	4,764	1,074,845			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,615,505	27,939	17,883	1,661,327		1,661,327		1,661,327			10
10a	Therapy	75,533		5,177	80,710		80,710		80,710			10a
11	Activities	96,024	2,710	4,743	103,477		103,477		103,477			11
12	Social Services	142,519		5,092	147,611		147,611		147,611			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,929,581	30,649	38,895	1,999,125		1,999,125		1,999,125			16
	C. General Administration											
17	Administrative	68,292		541,000	609,292		609,292	(494,458)	114,834			17
18	Directors Fees											18
19	Professional Services			49,941	49,941		49,941	9,476	59,417			19
20	Dues, Fees, Subscriptions & Promotions			32,940	32,940		32,940	(22,957)	9,983			20
21	Clerical & General Office Expenses	111,741	20,880	156,807	289,428		289,428	(94,134)	195,294			21
22	Employee Benefits & Payroll Taxes			452,612	452,612		452,612	(560)	452,052			22
23	Inservice Training & Education							80	80			23
24	Travel and Seminar			3,113	3,113		3,113	85	3,198			24
25	Other Admin. Staff Transportation			3,473	3,473		3,473	626	4,099			25
26	Insurance-Prop.Liab.Malpractice			148,787	148,787		148,787	2,458	151,245			26
27	Other (specify):*							8,825	8,825			27
28	TOTAL General Administration	180,033	20,880	1,388,673	1,589,586		1,589,586	(590,559)	999,027			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,688,085	354,284	1,616,423	4,658,792		4,658,792	(585,795)	4,072,997			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BOURBONNAIS TERRACE #0021550 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			58,258	58,258		58,258	2,914	61,172			30
31	Amortization of Pre-Op. & Org.			4,195	4,195		4,195		4,195			31
32	Interest			241,170	241,170		241,170	(78,367)	162,803			32
33	Real Estate Taxes			67,780	67,780		67,780	1,220	69,000			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			29,283	29,283		29,283	4,395	33,678			35
36	Other (specify):* OFFICE RENT			15,122	15,122		15,122	(15,122)				36
37	TOTAL Ownership			415,808	415,808		415,808	(84,960)	330,848			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			107,857	107,857		107,857		107,857			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			107,857	107,857		107,857		107,857			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,688,085	354,284	2,140,088	5,182,457		5,182,457	(670,755)	4,511,702			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,141	30		9
10	Interest and Other Investment Income	(80,435)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,176)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(22,540)	20		20
21	Owner or Key-Man Insurance	(560)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(298)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,449)	20		28
29	Other-Attach Schedule	2,087			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (103,230)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(567,525)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (567,525)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (670,755)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

BOURBONNAIS TERRACE

ID# 0021550

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 2,087	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	2,087		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,176)	0	0	0	0	0	0	0	0	0	0	(1,176)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	441	0	0	0	0	0	0	0	441	5
6	Maintenance	2,087	0	2,516	764	0	0	0	0	0	0	0	5,367	6
7	Other (specify):*	0	0	132	0	0	0	0	0	0	0	0	132	7
8	**TOTAL General Services**	911	0	2,648	1,205	0	0	0	0	0	0	0	4,764	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(504,170)	9,712	0	0	0	0	0	0	0	0	(494,458)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	282	8,917	277	0	0	0	0	0	0	0	9,476	19
20	Fees, Subscriptions & Promotions	(24,287)	0	1,330	0	0	0	0	0	0	0	0	(22,957)	20
21	Clerical & General Office Expenses	0	8,908	(103,180)	138	0	0	0	0	0	0	0	(94,134)	21
22	Employee Benefits & Payroll Taxes	(560)	0	0	0	0	0	0	0	0	0	0	(560)	22
23	Inservice Training & Education	0	0	80	0	0	0	0	0	0	0	0	80	23
24	Travel and Seminar	0	0	85	0	0	0	0	0	0	0	0	85	24
25	Other Admin. Staff Transportation	0	497	129	0	0	0	0	0	0	0	0	626	25
26	Insurance-Prop.Liab.Malpractice	0	1,080	1,267	111	0	0	0	0	0	0	0	2,458	26
27	Other (specify):*	0	2,730	6,095	0	0	0	0	0	0	0	0	8,825	27
28	**TOTAL General Administration**	(24,847)	(490,673)	(75,565)	526	0	0	0	0	0	0	0	(590,559)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(23,936)	(490,673)	(72,917)	1,731	0	0	0	0	0	0	0	(585,795)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number BOURBONNAIS TERRACE **#** 0021550 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	1,141	358	478	937	0	0	0	0	0	0	0	2,914	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(80,435)	0	0	2,068	0	0	0	0	0	0	0	(78,367)	32
33	Real Estate Taxes	0	0	0	1,220	0	0	0	0	0	0	0	1,220	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	1,258	2,914	223	0	0	0	0	0	0	0	4,395	35
36	Other (specify):*	0	0	0	(15,122)	0	0	0	0	0	0	0	(15,122)	36
37	**TOTAL Ownership**	(79,294)	1,616	3,392	(10,674)	0	0	0	0	0	0	0	(84,960)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(103,230)	(489,057)	(69,525)	(8,943)	0	0	0	0	0	0	0	(670,755)	45

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		EKS MNGT	LINCOLNWOOD	BOOKEEPING
				EMI ENTERPRISE	LINCOLNWOOD	MNGT CONSULTA
				IME REALTY	LINCOLNWOOD	HOME OFFICE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 520,000	EMI ENTERPRISES, INC		$	$ (520,000)	1
2	V								2
3	V								3
4	V	17	OFFICERS SALARY				15,830	15,830	4
5	V	19	ACCOUNTING FEES				282	282	5
6	V	21	OFFICE EXPENSE				8,908	8,908	6
7	V	25	TRANSPORTATION				497	497	7
8	V	26	INSURANCE				1,080	1,080	8
9	V	27	EMPLOYEE BENEFITS				2,730	2,730	9
10	V	30	DEPRECIATION				358	358	10
11	V	35	AUTO LEASE				1,258	1,258	11
12	V								12
13	V								13
14	Total			$ 520,000			$ 30,943	$ * (489,057)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	BOOKKEEPING FEES	$ 134,748	EKS MANAGEMENT, INC.		$	$ (134,748)	15
16	V								16
17	V								17
18	V	6	PAINTING SALARIES				2,516	2,516	18
19	V	7	SCAVENGER				132	132	19
20	V	17	CFO SALARY				9,712	9,712	20
21	V	19	PROFESSIONAL FEES				8,917	8,917	21
22	V	20	WANTS AD				1,330	1,330	22
23	V	21	OFFICE EXPENSE				31,568	31,568	23
24	V	23	SEMINARS				80	80	24
25	V	24	IN-STATE LODGING/MEALS				85	85	25
26	V	25	TRANSPORTATION				129	129	26
27	V	26	INSURANCE				1,267	1,267	27
28	V	27	EMPLOYEE BENEFITS				6,095	6,095	28
29	V	30	DEPRECIATION				478	478	29
30	V	35	EQUIPMENT RENTAL				2,914	2,914	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 134,748			$ 65,223	$ * (69,525)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	36	OFFICE RENT	$ 15,122	IME REALTY CORP.		$	$ (15,122)	15
16	V								16
17	V								17
18	V	5	UTILITIES				441	441	18
19	V	6	REPAIRS & MAINTENACE				764	764	19
20	V	19	PROFESSIONAL FEES				277	277	20
21	V	21	OFFICE EXPENSE				138	138	21
22	V	26	INSURANCE				111	111	22
23	V	30	DEPRECIATION				937	937	23
24	V	32	INTEREST				2,068	2,068	24
25	V	33	RE TAX				1,220	1,220	25
26	V	35	STORAGE FEES				223	223	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 15,122			$ 6,179	$ * (8,943)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BERNARD COHEN	GEN PARTNER	ADMINISTRATION		SEE ATTACHED SCHEDULE			MNGT FEE	$ 21,000	17-3	1
2	MORRIS ESFORMES	GEN PARTNER	ADMINISTRATION					SALARY	15,830	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 36,830		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	PATIENT DAYS	797,100	13	$ 185,000	$ 185,000	68,208	$ 15,830	1
2	19	ACCOUNTING FEES	PATIENT DAYS	797,100	13	3,299		68,208	282	2
3	21	OFFICE EXPENSE	PATIENT DAYS	797,100	13	104,106	76,720	68,208	8,908	3
4	25	TRANSPORTATION	PATIENT DAYS	797,100	13	5,805		68,208	497	4
5	26	INSURANCE	PATIENT DAYS	797,100	13	12,620		68,208	1,080	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	797,100	13	31,900		68,208	2,730	6
7	30	DEPRECIATION	PATIENT DAYS	797,100	13	4,180		68,208	358	7
8	35	AUTO LEASE	PATIENT DAYS	797,100	13	14,702		68,208	1,258	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 361,612	$ 261,720		$ 30,943	25

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MANAGEMENT
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	PAINTING / DECORATING	PATIENT DAYS	797,100	13	$ 29,397	$ 29,397	68,208	$ 2,516	1
2	7	SCAVENGER	PATIENT DAYS	797,100	13	1,544		68,208	132	2
3	17	CFO SALARY	PATIENT DAYS	797,100	13	113,499	113,499	68,208	9,712	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	797,100	13	104,205	93,812	68,208	8,917	4
5	20	WANTS AD	PATIENT DAYS	797,100	13	15,548		68,208	1,330	5
6	21	OFFICE EXPENSE	PATIENT DAYS	797,100	13	368,910	256,444	68,208	31,568	6
7	23	SEMINARS	PATIENT DAYS	797,100	13	940		68,208	80	7
8	24	IN-STATE LODGING/MEALS	PATIENT DAYS	797,100	13	994		68,208	85	8
9	25	TRANSPORTATION	PATIENT DAYS	797,100	13	1,506		68,208	129	9
10	26	INSURANCE	PATIENT DAYS	797,100	13	14,803		68,208	1,267	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	797,100	13	71,229		68,208	6,095	11
12	30	DEPRECIATION	PATIENT DAYS	797,100	13	5,592		68,208	478	12
13	35	EQUIPMENT RENT	PATIENT DAYS	797,100	13	34,056		68,208	2,914	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 762,223	$ 493,152		$ 65,223	25

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP.
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	268,762	13	$ 7,839	$	15,122	$ 441	1
2	6	REPAIRS & MAINTENANCE	INCOME	268,762	13	13,572		15,122	764	2
3	19	PROFESSIONAL FEES	INCOME	268,762	13	4,925		15,122	277	3
4	21	OFFICE EXPENSE	INCOME	268,762	13	2,448		15,122	138	4
5	26	INSURANCE	INCOME	268,762	13	1,978		15,122	111	5
6	30	DEPRECIATION	INCOME	268,762	13	16,647		15,122	937	6
7	32	INTEREST	INCOME	268,762	13	36,747		15,122	2,068	7
8	33	RE TAX	INCOME	268,762	13	21,685		15,122	1,220	8
9	35	STORAGE FEES	INCOME	268,762	13	3,962		15,122	223	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 109,803	$		$ 6,179	25

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	LASALLE NATL BANK		X	MORTGAGE	$27,208.00	11/01/01	$ 4,004,402	$ 3,899,378	10/31/26		$ 227,197	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LASALLE NATL BANK		X	LINE OF CREDIT	INTEREST	REVOLV			REVOLV	PRIME +	9,067	6
7			X	INSURANCE FINANCING							4,906	7
8												8
9	TOTAL Facility Related				$27,208.00		$ 4,004,402	$ 3,899,378			$ 241,170	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,004,402	$ 3,899,378			$ 241,170	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 69,290	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 68,535	2
3. Under or (over) accrual (line 2 minus line 1).		$ (755)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 68,535	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 67,780	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	60,461	8
	1998	61,858	9
	1999	60,602	10
	2000	68,983	11
	2001	68,535	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BOURBONNAIS TERRACE COUNTY KANKAKEE

FACILITY IDPH LICENSE NUMBER 0021550

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.	17-09-17-300-020	NURSING HOME	$ 68,535.00	$ 68,535.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 68,535.00	$ 68,535.00

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,232 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	165,000		$ 187,600	1
2					2
3	TOTALS	165,000		$ 187,600	3

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	197		1975	1974	$ 1,838,000	$		$	$	$ 1,838,000	4
5	Related										5
6	Party					937		937			6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENT			1981	54,211		10			54,211	9
10	LEASEHOLD IMPROVEMENT			1982	17,608		10			17,608	10
11	ROOFING			1983	1,875		15			1,875	11
12	ROOFING			1984	6,215	186	18	186		5,758	12
13	IMPROVEMENTS			1987	21,900	695	31.5	695		11,120	13
14	STONE DRIVE			1990	7,800	248	31.5	248		3,069	14
15	IMPROVEMENTS			1991	26,075	828	31.5	828		9,280	15
16	IMPROVEMENTS			1992	38,485	1,222	31.5	1,222		12,831	16
17	ROOFING			1993	21,500	551	39	551		6,569	17
18	GUTTERS			1994	7,248	186	39	186		1,604	18
19	CONCRETE			1994	7,967	204	39	204		1,709	19
20	FLOOR			1995	766	20	39	20		159	20
21	TILES			1995	1,580	40	39	40		320	21
22	FLOOR			1995	934	24	39	24		189	22
23	CONCRETE			1995	2,500	64	39	64		456	23
24	TILES			1996	5,820	149	39	149		987	24
25	SEWERS			1996	10,000	256	39	256		1,675	25
26	TILES			1996	16,056	412	39	412		2,695	26
27	ROOF			1996	21,650	555	39	555		3,585	27
28	CONCRETE			1996	7,949	204	39	204		1,301	28
29	SCREENS			1996	1,424	37	39	37		233	29
30	DISPOSER BASE UNIT			1996	732	19	39	19		115	30
31	FLOORING IMPROVEMENTS			1997	16,979	435	39	435		2,411	31
32	WINDOWS			1998	1,680	43	39	43		215	32
33	INSTALL NEW SIGN			1998	2,643	68	39	68		275	33
34	NURSES STATION			1999	3,520	90	39	90		342	34
35	KITCHEN A/C UNIT			1999	6,696	172	39	172		595	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	FURNISHING - CARPET / WALLPAPER	1999	$ 16,384	$ 2,046	7	$ 4,012	$ 1,966	$ 14,377	37
38	FENCE	2000	2,800	187	15	187		522	38
39	DUCT WORK	2000	14,000	509	27.5	509		1,082	39
40	IN WALLS HEATERS	2000	12,407	451	27.5	451		1,334	40
41	IN WALLS HEATERS	2000	4,378	159	27.5	16	(143)	65	41
42	FURNISHING	2000	23,248	4,066	7	3,321	(745)	9,964	42
43	DOORS	2000	881	32	27.5	32		95	43
44	IMPROVEMENT - BATHROOM	2001	2,782	101	27.5	101		156	44
45	IMPROVEMENT - HVAC UNITS	2001	15,737	572	27.5	572		882	45
46	IMPROVEMENT - BUILT IN CLOSETS	2001	60,000	2,182	27.5	2,182		3,364	46
47	IMPROVEMENT - WINDOWS	2001	2,995	109	27.5	109		218	47
48	FURNISHING - TILE FLOOR	2001	5,208	1,667	5	1,041	(626)	2,083	48
49	IMPROVEMENT - ROOF	2002	52,300	1,347	27.5	1,347		1,347	49
50	IMPROVEMENT - HEATING & AIR CON	2002	27,923	550	27.5	550		550	50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,390,856	$ 21,623		$ 22,075	$ 452	$ 2,015,226	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 413,864	$ 31,542	$ 37,576	$ 6,034	10 YRS	$ 280,099	71
72	Current Year Purchases	13,704	6,030	685	(5,345)	10 YRS	685	72
73	Fully Depreciated Assets	284,810					284,810	73
74	RELATED PARTY		836	836				74
75	TOTALS	$ 712,378	$ 38,408	$ 39,097	$ 689		$ 565,594	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,290,834	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 60,031	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 61,172	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,141	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,580,820	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BOURBONNAIS TERRACE STATE OF ILLINOIS # 0021550 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		197		$			3
4	Additions							4
5								5
6								6
7	TOTAL		197		$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 22,573 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	MAINT / ACTIVITY	1999 FORD E350 VAN	$ 550.99	$ 6,710	17
18					18
19					19
20					20
21	TOTAL		$ 550.99	$ 6,710	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number BOURBONNAIS TERRACE **#** 0021550 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 43,396	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,066,887		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	105,796		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,943,584		8
9	Other(specify): EMPL LOANS, ADV WA	13,266		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,172,929	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	187,600		13
14	Buildings, at Historical Cost	1,838,000		14
15	Leasehold Improvements, at Historical Cost	552,856		15
16	Equipment, at Historical Cost	712,378		16
17	Accumulated Depreciation (book methods)	(2,678,012)		17
18	Deferred Charges	35,369		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): AMORT OF DEF LOAN	(4,894)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 643,297	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,816,226	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 129,786	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	88,648		30
31	Accrued Taxes Payable (excluding real estate taxes)	33,612		31
32	Accrued Real Estate Taxes(Sch.IX-B)	68,535		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO RELATED PARTIES	56,596		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 377,177	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,899,378		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,899,378	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,276,555	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (460,329)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,816,226	$	48

***(See instructions.)**

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (700,644)	1
2	Restatements (describe):		2
3	ROUNDING	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (700,642)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	773,563	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(533,250)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 240,313	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (460,329)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,875,585	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,875,585	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	80,435	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 80,435	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,956,020	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,070,081	31
32	Health Care	1,999,125	32
33	General Administration	1,589,586	33
	B. Capital Expense		
34	Ownership	415,808	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	107,857	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,182,457	40
41	**Income before Income Taxes (line 30 minus line 40)****	773,563	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 773,563	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.** **Tax Return Cash Basis**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,773	1,773	$ 50,953	$ 28.74	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,666	2,881	52,283	18.15	3
4	Licensed Practical Nurses	24,333	27,366	462,655	16.91	4
5	Nurse Aides & Orderlies	70,965	80,179	939,287	11.71	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,977	5,639	75,533	13.39	8
9	Activity Director					9
10	Activity Assistants	8,340	9,349	96,024	10.27	10
11	Social Service Workers	12,246	12,549	142,519	11.36	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,181	22,750	258,258	11.35	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,120	24,020	11.33	17
18	Housekeepers	18,277	20,353	204,630	10.05	18
19	Laundry	6,567	7,459	91,563	12.28	19
20	Administrator	2,080	2,180	68,292	31.33	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,599	11,463	111,741	9.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	6,474	7,074	110,327	15.60	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	191,558	213,135	$ 2,688,085 *	$ 12.61	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 9,630	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	1,902	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	7,502	10-3	39
40	Physical Therapy Consultant	L	2,831	10a-3	40
41	Occupational Therapy Consultant	Y	2,346	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	4,743	11-3	44
45	Social Service Consultant	E	5,092	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 40,046		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	40	$ 1,077	10-3	50
51	Licensed Practical Nurses	16	272	10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)	56	$ 1,349		53

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DEBRA WOODS	ADMIN		$ 68,292
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 68,292

B. Administrative - Other

Description	Amount
EMI ENTERPRISES MANAGEMENT FEES	$ 520,000
BERNARD COHEN MANAGEMENT FEES	21,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 541,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
KBKB, LTD	ACCOUNTING	$ 16,100
LAWRENCE SCHWARTZ	LEGAL	9,000
MC BRIDE, BAKER	LEGAL	930
PERSONNEL PLANNERS	UNEMPLOYMENT CNSTNT	769
PROFESSIONAL ASSOC	CONSULTANT	3,800
PRO CLAIM AMERICA	W/C CONSULTANT	2,526
JOSEPH SANDER	PSYCHOLOGICAL SERV	2,400
ALPHA DATA	DATA PROCESSING	4,338
NCS	DATA PROCESSING	7,390
MAXX SOURCE	DATA PROCESSING	1,250
LTC SOLUTION	DATA PROCESSING	1,320
SOURCE TECH	DATA PROCESSING	118
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 49,941

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 82,341
Unemployment Compensation Insurance	13,812
FICA Taxes	205,639
Employee Health Insurance	149,481
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	779
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	560
INSURANCE - EXECUTIVE LIFE VI 21	(560)
TOTAL (agree to Schedule V, line 22, col.8)	$ 452,052

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,798
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	1,747
TRUST/FRANCHISE/CONTRIB/ETC	22,540
LICENSES & PERMITS	485
DUES & SUBSCRIPTIONS	6,370
MGMT CO ALLOCATION	1,330
TRUST/FRANCHISE/CONTRIB/ETC	(22,540)
Less: Public Relations Expense	(0)
Non-allowable advertising	(298)
Yellow page advertising	(1,449)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,983

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
SEMINAR AND EDUCATION	3,113
MGMT ALLOC	85
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,198

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINT / DECORATING	1997	$ 6,090	3	$ 2,030	$ 1,015	$	$	$	$	$	$	$
2	PAINT / DECORATING	1998	2,585	3	862	862	430						
3	PAINT / DECORATING	1999	2,551	3	425	850	850	426					
4	PAINT / DECORATING	2000	2,926	3		488	975	975	488				
5	PAINT / DECORATING	2001	1,458	3			243	486	486	243			
6	PAINT / DECORATING	2002	1,199	3				200	400	400	199		
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 16,809		$ 3,317	$ 3,215	$ 2,498	$ 2,087	$ 1,374	$ 643	$ 199	$	$

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LONG TERM $ 5,891.**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **107,857**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: BOURBONNAIS TERRACE #0021550 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	9,630	
	REPAIRS & MAINTENANCE		0	
			0	9,630
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		3,902	
			0	3,902
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		12,111	
	ELECTRICITY		65,439	
	WATER		43,624	
	CABLE TV - LOBBY		6,104	
			0	127,278
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,909	
	PAINTING & DECORATING		1,199	
	BUILDING REPAIRS		11,229	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		18,181	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,995	
	FIRE SERVICE		1,787	
			0	
			0	
			0	39,300
7	**OTHER**			
	SCAVENGER		8,441	
	SECURITY SERVICE		304	8,745
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000	6,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	1,349	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		2,830	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,902	
	PHARMACY CONSULTANT	XVIII B 39-2	7,502	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	1,000	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL SERVICES		3,300	
			0	17,883
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	2,831	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	2,346	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	5,177
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	4,743	
			0	4,743
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	5,092	
			0	5,092
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BOURBONNAIS TERRACE **#0021550** **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	541,000	541,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	14,416	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	35,525	
			0	49,941
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	298	
	EMPLOYEE WANT ADS	XIX F	1,798	
	CONTRIBUTIONS	VI 20 XIX F	750	
	DUES & SUBSCRIPTIONS	XIX F	6,370	
	LICENSES & PERMITS	XIX F	485	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,449	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	21,790	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	32,940
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		8,596	
	EQUIPMENT REPAIR & MAINTENANCE		333	
	OUTSIDE CLERICAL SERVICES		134,748	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		13,130	
	MESSENGER SERVICE		0	
			0	156,807

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	205,639	
	UNEMPLOYMENT COMPENSATION	XIX D	13,812	
	WORKERS COMPENSATION INSURANC	XIX D	82,341	
	HOSPITALIZATION INSURANCE	XIX D	149,481	
	EMPLOYEE BENEFITS - OTHER	XIX D	779	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	560	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	452,612
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	3,113	
	TRAVEL	XIX G	0	
			0	
			0	3,113
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		3,473	3,473
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		148,787	148,787
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,616,423

BOURBONNAIS TERRACE
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	239,621	PATIENT MEALS	204624
LESS SALES TAX	(1,176)	ADD EMPLOYEE MEALS	0
NET FOOD	238,445	TOTAL MEALS/YEAR	204624
TOTAL PATIENT CENSUS	68,208	NET FOOD	238445
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	204624
TOTAL PATIENT MEALS	204624	COST PER MEAL	1.17
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		